Advanced Practice Registered Nurse: Full Practice Authority

Support for Michigan Senate Bill 2

Grace Jacek, MSN, APRN-BC, Doctoral Student

Kathy Moran, DNP, RN, CDE, Assistant Professor

University of Detroit-Mercy

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The Michigan legislature is modernizing Michigan's public health codes (PHC) to meet the needs of Michigan residents while the nation's healthcare system is changing and the aged population is growing. Currently Michigan's laws are outdated relevant to the scope of practice for advanced practice registered nurses (APRNs). APRNs include certified nurse midwives (CNM), clinical nurse specialists (CNS) and nurse practitioners (NP). The present PHC permits APRNs to do what physicians delegate and it does not differentiate between Registered Nurses (RNs) and APRNs. Delegation of practice is broader and less specific then the proposed legislation (Senate Bill 2) that sits before Michigan's House of Representatives Health Policy Committee. Senate Bill 2 defines Michigan APRN scope of practice. Presently, there is no description in Michigan's statute that specifically outlines the scope of practice for APRNs. This reflects discordance between the vaguely defined scope of practice set forth by outdated statutes and the current education/training of the APRN. In addition, the current outdated legislation has promoted anti-competitive practices towards the nursing profession, and APRNs, from professions outside of nursing. This restraint of trade has impaired healthy competition in the healthcare market. Currently APRNs have two alternatives to choose from; APRNs may pursue their own professional destiny or they may do nothing and let other professions choose for them.

BACKGROUND

According to the American Association of Nurse Practitioners (AANP, 2013), approximately one-third of the nation has updated their state laws to adopt full practice authority licensure for APRNs. The states that have updated their PHCs to grant full practice authority to APRNs include: Alaska, Colorado, District of Columbia, Hawaii,

Iowa, Maine, Montana, Nevada, New Hampshire, New Mexico, North Dakota, Oregon, Rhode Island, Vermont, Washington and Wyoming. States, in addition to Michigan, that are currently amending their legislation to address full practice authority include: Kansas, Massachusetts, Nebraska, New Jersey, Pennsylvania, Minnesota, Kentucky and Ohio.

According to the AANP (2013) the definition of full practice authority is as follows: "Full practice authority is the collection of state practice and licensure laws that allow for NPs to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments, including prescribe medications under the exclusive licensure authority of the State Board of Nursing" (pg. 1)

On March 23, 2010 the Patient Protection and Affordable Care Act (ACA) was signed into law. ACA requires that all citizens have qualifying health insurance coverage beginning January 1, 2014. With full implementation of the ACA, 32 million patients will enter the health care system, resulting in increased utilization of primary care services. In order to accommodate this influx of patients, Michigan must modernize its PHC related to APRN scope of practice. In states where outdated scope of practice legislation persists, like Michigan, APRNs ability to meet health care demands will be impeded.

Outdated scope of practice laws are generally imposed in states where nursing faces supervision by professions outside of itself. There is no evidence to support that the nursing profession, or the public, benefits from this scenario, but rather the supervising professions are the beneficiaries. The scope of practice restrictions

imposed on NPs may result in some regions facing unnecessary challenges to accessing primary care services. This is a problem that is likely to worsen over time.

The Michigan Senate passed Senate Bill 2 (SB2) in October 2013. The bill is currently under consideration by the House Health Policy Committee. The key topics for Senate Bill 2 include full practice authority for APRNs with State Board of Nursing oversight, prescriptive authority and prescribing physical and occupational therapy. SB 2 will not only update Michigan's PHC, it will create a licensing procedure for APRNs with oversight from the Board of Nursing (BON). The Bill limits the scope of practice for APRNs to practice within the parameters of their certification, education and training, such as graduate level preparation, prescriptive authority, controlled substance licensure with participation in the MI Automated Prescription System (MAPS), and mentorship requirements. The Bill also creates an APRN Task Force advisory panel for the BON. SB2 does not prohibit voluntary collaborative agreements between physicians and APRNs.

ORGANIZATIONS IN SUPPORT OF APRN FULL PRACTICE AUTHORITY

In 2011, the Institute of Medicine (IOM, 2011), Future of Nursing report urged all policy makers to recognize nurses and legislate their scope of practice to the full extent of their education and training. In this report there was a sub-recommendation made to the Federal Trade Commission to reduce anti-competitive conduct in the health care market. The IOM further recommended leadership should be cultivated in the nursing profession. Nurses should participate in decision-making and actively participate in healthcare reform. And in an effort to advance health systems, nurses should be

included on advisory boards. It is the opinion of the IOM; that these changes will promote seamless, affordable, and quality health care by extending full practice authority to APRNs.

The American Association of Retired Persons (AARP) believes that consumers will benefit from APRN full practice authority (Brassard and Smolenski, 2011). The AARP states society benefits when other professionals are educated about the role of APRNs. Brassard (2012) posits that the healthcare system will benefit when APRNs can certify home health and hospice service. Further, the AARP believes continuity of care will improve when NPs, while providing house calls and primary care services, are allowed to certify home health and hospice services. Research reveals that NPs can perform many primary care services as well as physicians do and achieve equal or higher patient satisfaction rates among their patients (Schiff, 2012, p. 11).

The National Governors Association (NGA) is another organization that supports changing scope of practice laws for APRNs. Additionally, the NGA encourages changes in the current reimbursement structure for APRN services to incentivize nurse practitioner involvement in primary healthcare services. Reimbursement reform is also supported by the Bipartisan Policy Center (BPC).

In 2013, the Bipartisan Policy Center (BPC) issued the following statement in their executive summary, "eliminate outdated statutory or regulatory requirements in Medicare and Medicaid that interfere with states' abilities to regulate and determine scopes of practice" (p.16). The BPC recommended that Congress should strike

language from the Medicare statute that requires physician collaboration and supervision as a mandate of direct nurse practitioner reimbursement.

By 2014, the Federal Trade Commission (FTC, 2014) recommended that legislators "apply a competition-based analytical framework" and scrutinize statements regarding health and safety justifications against full practice authority. The FTC acknowledges empirical research that indicates APRNs can safely provide healthcare in diverse primary care settings. In fact, the FTC states there was no evidence suggesting safety and quality of primary care services deteriorated in states where APRN supervision or collaborative practices were eliminated or reduced. The FTC further states effective collaboration between APRNs and physicians does not require supervision.

The AANP (2013) postulates physicians benefit by being unburdened with bureaucratic restriction that mandates physician involvement in NP patient care. Duplication of care and costs will be reduced. Physician signatures will not be required therefore; the public will experience a reduced delay in care. Collaboration will take place under the auspices of professional courtesy.

Individually, many physicians support SB2 for a variety of personal and professional reasons. Some physicians express a desire to not be burdened with supervising NPs or co-signing orders for patients to access other services needed during the delivery of primary care, such as home health, hospice, medical equipment and physical/occupational therapy. In addition, some physicians feel their professional organization's opposition to APRN full practice authority is unwarranted.

ORGANIZATIONS IN OPPOSITION TO APRN FULL PRACTICE AUTHORITY

There are physician organizations that do not support SB2 citing concern for health and safety of patients (i.e., Michigan State Medical Society, Michigan Osteopathic Association and Michigan Radiological Society). The Wayne County Medical Society (WCMS) and the American Academy of Family Physicians (AAFP) have spoken out against SB2. Across the nation, some physician groups have expressed opposition towards APRN full scope of practice.

WCMS (2013) issued a call for action urging physicians to contact their legislators to express opposition against SB2. The WCMS states the laws in MI are sufficient for all APRNs to prescribe medications with physician oversight. They believe education and training should determine scope of practice and not statutes. It is the position of the WCMS, that the current laws protect people in the care of physicians and nurses and reducing educational requirements puts patients at risk. The WCMS does not believe access to care will improve as a result of SB2 or full practice authority for APRNs.

In 2010, the AAFP announced that its' Congress of Delegates requested that the AAFP fund a study comparing the practices of primary care physicians and nurse practitioners. The AAFP (2012) issued their position on APRN full practice authority. They state, "Substituting NPs for doctors cannot be the answer. Nurse practitioners are not doctors, and responsible leaders of nursing acknowledge this fact" (pg. 573). It is unclear presently, where the AAFP Congress of Delegates is in their research process to compare primary care physicians and nurse practitioners. Hopefully, transparent

APRN practice outcomes (buried in physician data) will be used to accurately compare primary care physicians and nurse practitioners.

The AAFP quoted Kathleen Potempa, Ph.D., R.N., Dean of the University of Michigan School of Nursing and president of the American Association of Colleges of Nursing out of context. The AAFP posted Dr. Potempa's quote in a New York Times article, "Nurses are very proud of the fact that they're nurses, and if nurses had wanted to be doctors, they would have gone to medical school."

APRNs are seeking full practice authority of advanced practice nursing and are not, in any way, laying claim to be physician-like. APRNs are nurses that specialize and define their population of interest from the very beginning of their graduate level education. Many APRNs take care of thousands of patients in their career before beginning graduate school. While some medical groups may claim boundaries they hold out to be the purview of medicine, advanced practice nurses have the board certifications to prove their specialty is well within the scope of advanced practice nursing. There is high level evidence that demonstrates full practice authority for APRNs is beneficial to consumers and will enhance the overall efficiency of our healthcare system. Society does not benefit from restraint of trade. The current status of the healthcare system is evidence of that.

The AANP (2013) also suggests that APRNs avoid using terminology such as "autonomous" and "independent", which may be misconstrued as "exclusive entrepreneurial efforts". We must build collegial relationships with other professionals in

the health care system. We must appreciate opinions from all professional organizations and not address opposition with adversarial language or rhetoric.

HIGH LEVEL EVIDENCE SUPPORTS APRN FULL PRACTICE AUTHORITY

Mundinger, Kane, Lenz (2000) conducted a randomized control trial to compare outcomes for patients randomly assigned to nurse practitioners and physicians for primary care follow-up after emergency department or urgent care visits. The nurse practitioner and physician groups had the same degree of independence for direct comparison. The results showed no significant differences between the two groups with regard to patients' health status. Physiological test results for asthma and diabetes were not different between the two groups. Patients with hypertension had statistically significant lower diastolic pressure in the nurse practitioner group. There were no differences between the groups with regard to patient satisfaction and health services utilization. The researchers concluded the two groups were comparable.

Laurant, Reeves, Hermens, Braspenning, Grol and Sibbald (2009) conducted a review of the literature with meta-analysis of data derived from randomized control trials, controlled before-and-after studies and interrupted time series examining longitudinal data comparing outcomes for patient, process of care, resource utilization, direct services and indirect societal costs. The researchers concluded that nurses produced as high a quality of care as primary care physicians. Their review of the research suggested 25-70% of the work undertaken by physicians might be moved to nurses. Nurses were valued to undertake health promotion in family practice and instrumental for routine management of chronic diseases (pg.2).

According to Newhouse, Stanik-Hutt, White, Johantgen, Bass and Zangaro (2011), a systematic review of the literature revealed a high level of evidence to support patient satisfaction with NPs and physicians was equivalent. In fact, when comparing clinical management of glucose control, blood pressure, emergency department visits, hospitalizations, length of stay and mortality; outcomes between NPs and physicians were equivalent. When comparing NP and physician management of lipid control, there was a high level of evidence to support better management of patient serum levels by NPs. This systematic review examined APRN outcomes for a span of over 18 years.

Martinez-Gonzalez, Tandjung, Djalali (2014), researchers from the Institute of Primary Care, University of Zurich systematically searched OVID, Medline, Embase, The Cochrane Library, and CINAHL and selected peer-review randomized control trials comparing physician care with nursing care and the impact on clinical parameters. They included in their meta-analysis nurse-led care of patients with complex conditions such as HIV, hypertension, congestive heart failure, cerebrovascular disease, diabetes mellitus, asthma, Parkinson 's disease and incontinence. There was no statistical difference between physician-led care and nurse-led care for lowering diastolic blood pressure, total cholesterol and HbA1c. There was one exception; the nurse-led patient group showed statistically significant lower systolic blood pressure as compared to the physician-led care group.

PHYSICIAN EDITORIAL IN SUPPORT OF SB2

Dr. David Gorski (2014) supports APRN full practice authority. He stated,

> The MSMS and the rest of the Michigan medical societies who make this argument are, quite simply, wrong. The scientific literature does not support them, and I rather suspect that they know it. If they had any outcomes data to support their fear mongering, they would have cited it. They don't, because there isn't any. Even the Institute of Medicine says so, and I bet any of my colleagues who oppose SB2 can't prove me wrong.

In response to physician-opposition groups citing patient safety concerns, Dr. Gorski (2014) states,

> To illustrate what I mean, let me ask: What happens when a *physician* encounters something in the course of diagnosis or treatment that goes very wrong and he doesn't have the training to handle? He calls in other physicians who *can* handle it.

This type of collaboration will be preserved in APRN practice moving forward, as it has been historically utilized in multi-disciplinary healthcare settings.

ALTERNATIVE TO APRN FULL PRACTICE AUTHORITY

One alternative is to not address APRN scope of practice under the guise of jeopardizing quality and safety in the Michigan healthcare system. Nursing could continue to allow professions outside of nursing to define nursing's role in our changing healthcare environment; however there is no evidence to support that the public will benefit from nursing's inaction in this matter. And there is no evidence to support that the public benefits from the oversight of nursing from non-nursing professions. The evidence suggests the public does not benefit from restraint of trade, in fact, the public

will suffer the adverse consequences of anti-competition modus operandi within the healthcare market if the status quo continues.

CHALLENGES TO INTEGRATION OF FULL PRACTICE AUTHORITY

Currently many health insurers and hospital associations have not issued public support or opposition for SB2 or APRN full practice authority issues. However, UnitedHealth Group's Center for Nursing Advancement issued an opinion stating nurse practitioners practicing in retail clinics deliver significant cost savings in the care and treatment of common conditions. Spetz, Parente, Town and Bazarko (2012) analyzed multistate insurance claims data from 2004-2007 involving cost-per-episode in states where NPs are allowed to practice independently and to prescribe independently. The authors found visits to retail clinics were associated with lower costs per episode, compared to episodes of care that did not begin with a retail clinic visit, and the costs were even lower when NPs practiced independently. The researchers state that approximately 27% of emergency department visits could have been handled appropriately at retail clinics and urgent care centers, at an approximate savings of $4.4 billion per year.

The American Nurses Association (ANA, 2013) has urged the Centers for Medicare & Medicaid Services (CMS) to introduce policy requiring health insurers within state exchanges to include APRNs as part of their network plans. Currently nurse practitioners may be listed as primary providers in hospice programs, but nurse practitioners may not certify beneficiaries to be eligible for hospice.

The AARP (Brassard & Simolenski, 2011) states the benefits to APRN full practice authority include expanding consumer choice and access to care; improving continuity of care, increasing cost-effectiveness, improving inter-professional collaboration and team care; improving education of other professionals about the role of APRNs, increasing long-term survivorship in multi-system, chronic disease and complex cancer patients; decreasing patient stressors, providing models for hospitals to credential APRNs and using available health care workforce most efficiently to coordinate care.

According to Poghosyan, Lucero, Rauch and Berkowitz (2012), the recognition of NPs as primary providers will allow their health care data to be tracked. This will allow for trending of performance measures and increase accountability. Transparent NP data will benefit society. Some organizations that oppose SB2 and APRN full practice authority hold the position that there is no evidence of cost-effectiveness justifying APRN recognition as primary care providers. This is due to the current complicated reimbursement structure and is not indicative of APRN performance. The current billing and reimbursement processes bury much of APRN performance data within physician practices; resulting in a limited cost/benefit analysis. It is the right of Michigan consumers to see APRN quality indicators and measures.

The passage of SB2 may have some challenges statewide including educating hospital boards, credentialing committees and medical staff to the benefits of modernizing hospital bylaws, increasing APRN presence on hospital committees, educating consumers about the benefits of continuity of care and transitional care (Brassard, 2011).

SB2 will continue to prohibit APRNs from forming Professional Limited Liability Companies (PLLCs) or Professional Services Corporations (PCSs). APRNs may not be a shareholder/member of Professional Corporation (P.C.). Therefore, APRNs presently will not benefit from the same laws that protect licensed physicians and attorneys as individuals from their business entities.

APRNs must continue to demonstrate original research contributing to healthcare science and work towards recognition as a learned profession. It is incumbent upon APRNs to seek legislative change in Michigan to assure APRNs reach this goal. The current laws in place are outdated. APRNs should benefit from laws that protect the individual practitioner as individuals from their business entities, much like physicians and attorneys currently do in professional corporations.

Presently APRNs are not reimbursed at 100% by Medicare (Poghosyan, et al., 2012). It is unclear how SB2 will impact reimbursement for APRN services. APRNs must continue to pursue policy change to address reimbursement issues. Currently there are complex reimbursement practices that often reimburse NPs less than primary care physicians. Some states have made legislative changes to allow NPs to be recognized as primary care providers to third-party payers; however, the legislation does not necessarily mean NPs are recognized in their organizations as the same.

RECOMMENDATIONS

It is recommended that legislators pass the updated public health code recognizing APRN full practice authority. This legislation is needed to stop restraint of

trade, create healthy competition within the healthcare market, lower healthcare costs and increase access to primary care providers for Michigan constituents.

SUMMARY

Full practice authority allows society to benefit from autonomous and unimpeded practice by APRNs as Michigan consumers gain increased access to healthcare services. More specifically, the public beneficiaries of APRN full practice authority will be consumers in Michigan's rural and urban underserved areas. Michigan consumers, in general, will have more choices in healthcare providers.

While SB2 does recognize full practice authority for APRNs in Michigan, there are continued challenges to alleviate some of the anti-competitive practices in the healthcare market imposed by outdated legislation. A multitude of credible professional organizations and government agencies support change to Michigan PHC to facilitate full practice authority for APRNs. The IOM, AARP, NGA, BPC, FTC and AANP have voiced strong support for APRN full practice authority. Numerous researchers have proven that quality and safety in healthcare outcomes is preserved with APRN intervention. While many physicians support SB2, APRNs have a responsibility to address opposition and pushback from other professional organizations in order to maintain a collegial and collaborative relationship with all stakeholders. Michigan's APRNs will continue to strive to alleviate the concerns of opposition groups, because it is the APRNs responsibility to pursue and shape the course of its profession in this changing healthcare environment.

It is largely the APRN vision to direct the course of APRN practice without oversight from professions outside of nursing, through the support of legislators. APRNs are asking for the support of legislators to update the public health code, support high quality APRN care provided to Michigan residents – vote Yes for APRN full practice authority.

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